



Federal Health Care Spending: Why Is It Growing? What Could Be Done About It?

Presentation at Williams College

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February 27, 2014

Notes for the slides can be found at the end of the presentation.

CBO's Approach to Policy Analysis

CBO Provides Objective, Nonpartisan Information to the Congress

CBO makes **baseline projections** of federal budget outcomes under current law.

CBO makes **estimates of the effects of changes in federal policies** (sometimes in collaboration with JCT):

- Legislation being developed by committees

- Conceptual proposals being discussed on the Hill or elsewhere

CBO makes **no recommendations**.

CBO's Estimates...

Focus on the **next 10 years**, but **sometimes look out 20 years** or more

Are meant to reflect the **middle of the distribution** of possible outcomes

Incorporate **behavioral responses** to the extent feasible

Use whatever **evidence** can be brought to bear given available resources and time

Change in **response to new analysis** by CBO and others

Provide **explanations of the analysis** to the extent feasible

CBO Analyzes Different Types of Effects of Health Care Policies

On the **federal** budget (always)

On **state governments'** budgets (sometimes)

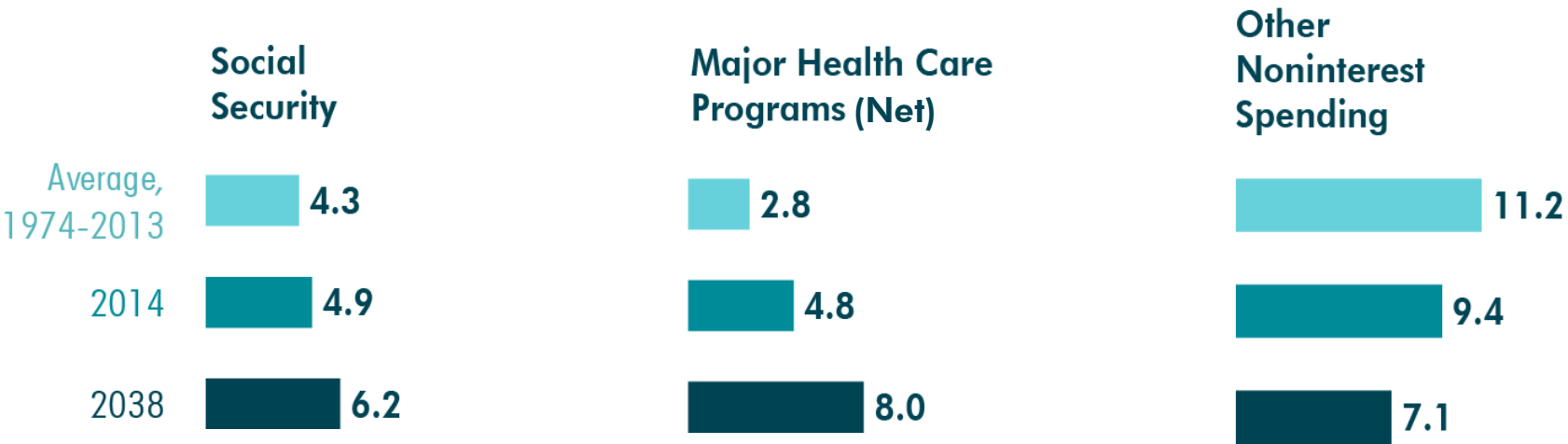
On **beneficiaries'** costs (sometimes)

On **health care** (hopefully in the future)

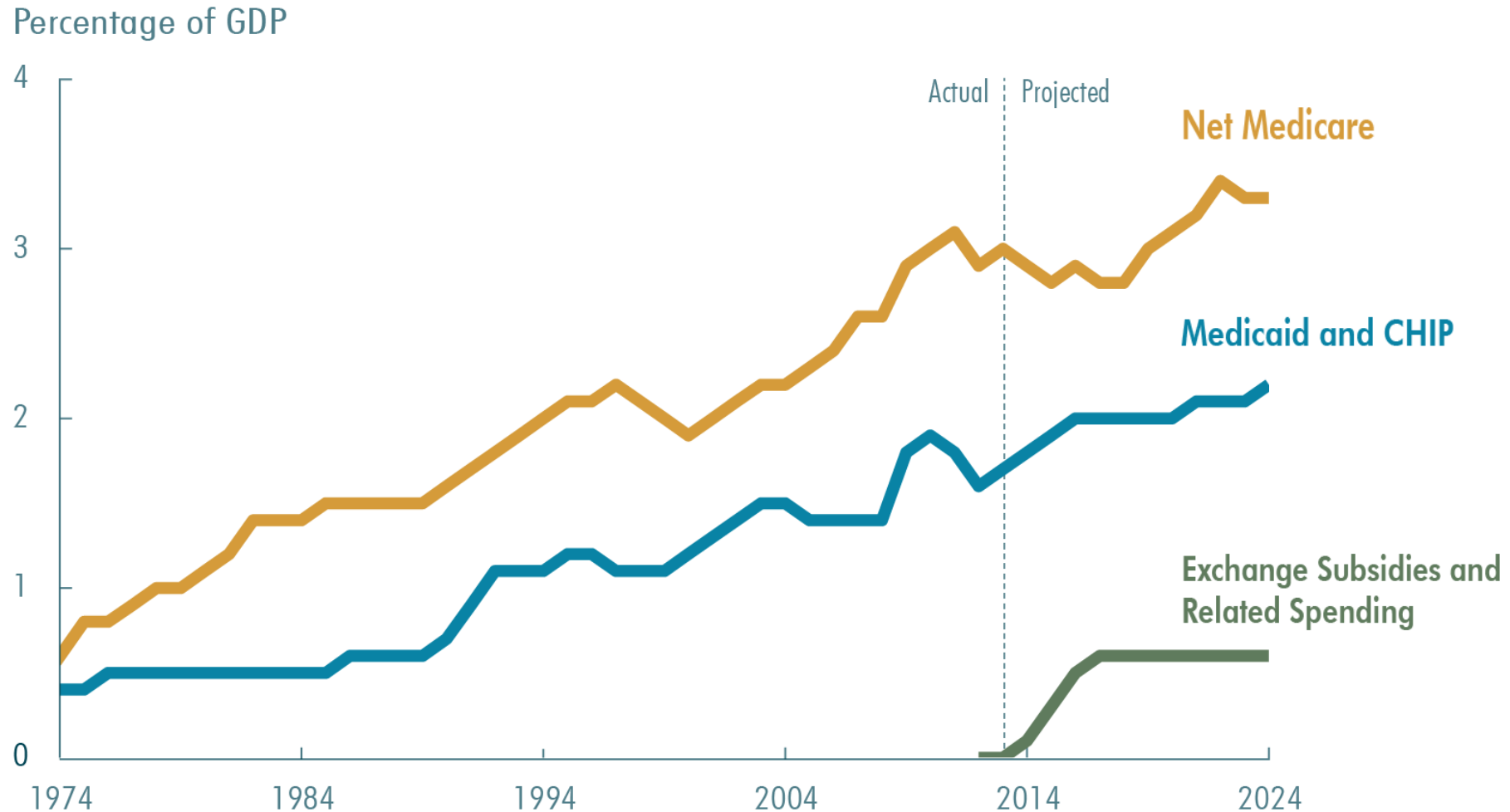
Why Is Federal Health Care Spending Growing?

Under Current Law, Federal Spending for Health Care Is Growing Much Faster Than Other Spending and the Economy

Percentage of GDP



Under Current Law, Federal Spending for Each Major Health Care Program Will Grow Rapidly

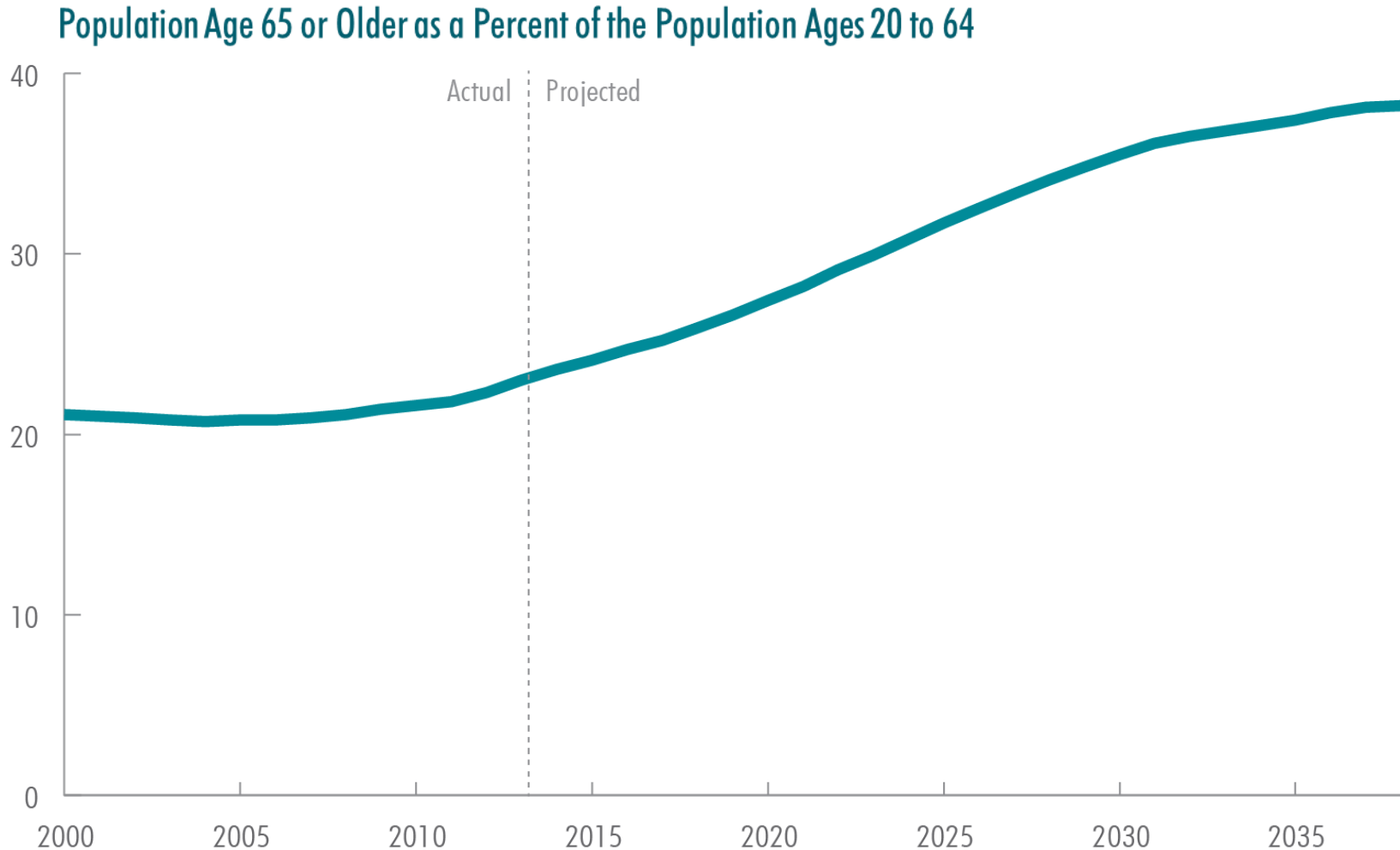


Federal Spending for Major Health Care Programs Will Increase Relative to GDP for Three Main Reasons

Percentage of Projected Growth in Spending Through:

	2023	2038
Population Aging	21	35
Expansion of Federal Subsidies for Health Insurance Through Medicaid and Exchanges	53	26
Rising Costs of Health Care Per Person	26	40

The Share of the Population Age 65 or Older Is Rising Substantially



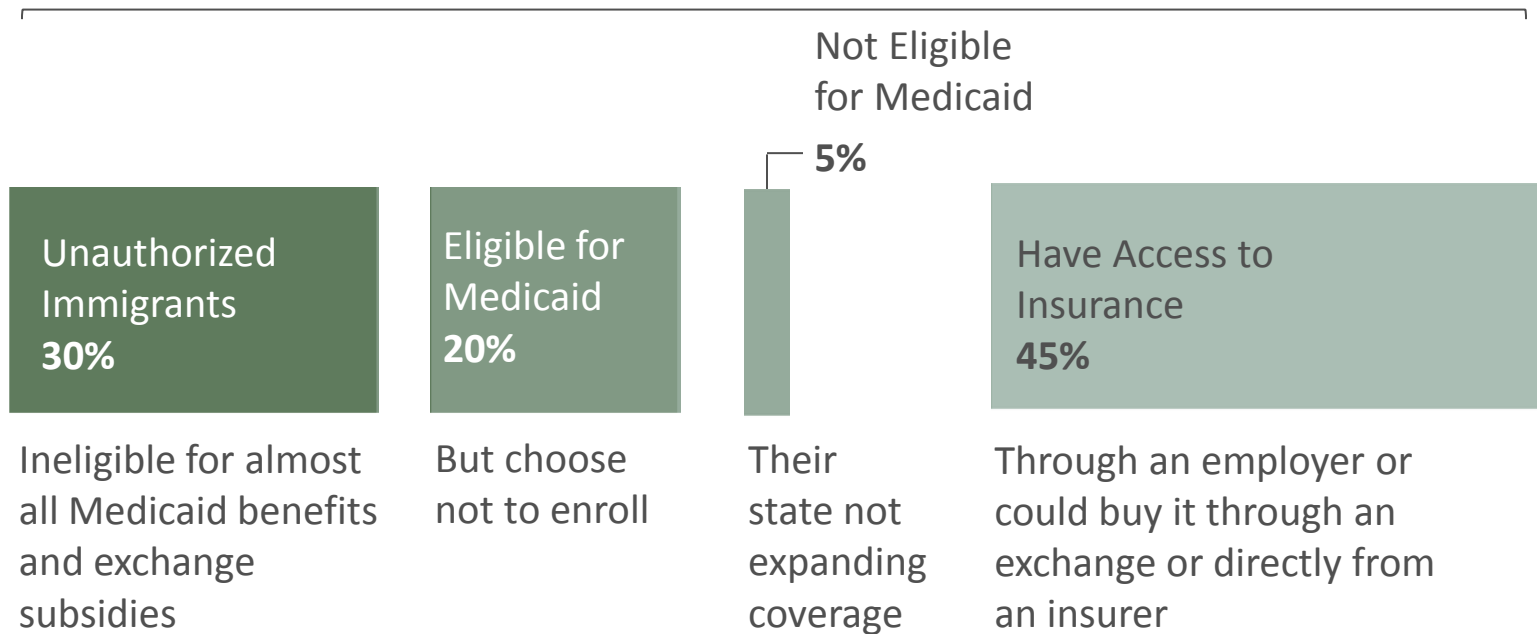
The Affordable Care Act Will Significantly Reduce the Number of People Without Health Insurance

Projections for 2023, People Under Age 65

Under Prior Law: **57 Million** Uninsured



Under the ACA: **31 Million** Uninsured



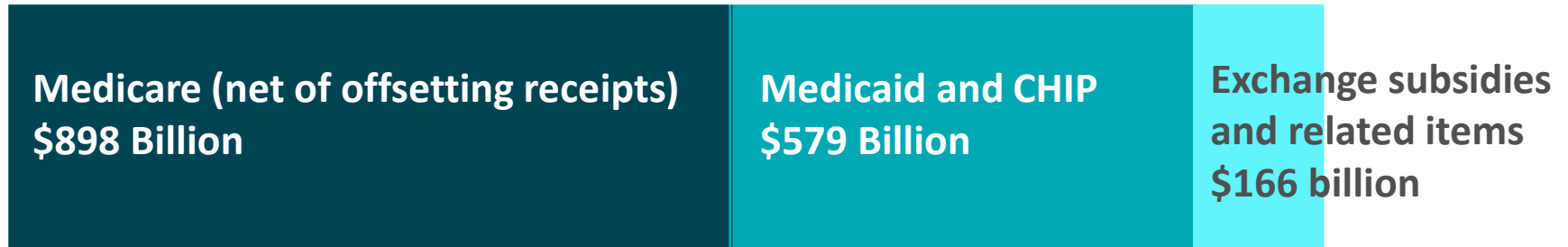
ACA Coverage Provisions Will Have Little Effect on Most Other People

Projections for 2023 for people under age 65 relative to prior law:

- 7 million** Fewer people, on net, will have employment-based health insurance.
- 10 to 15 million** People who would have bought insurance in the nongroup market without the ACA will face higher premiums before subsidies, on average—primarily because insurance policies will be required to cover a larger share of health care costs. Some but not all of those people will receive subsidies through the exchanges.
- 200 million** People who would have had employment-based health insurance or been covered by Medicaid without the ACA will have the same source of coverage and face similar costs for insurance (apart from any effect of the excise tax on high-premium plans).

Even After the Affordable Care Act Is Fully Implemented, Most Federal Spending for Health Care Will Support Care for Older People

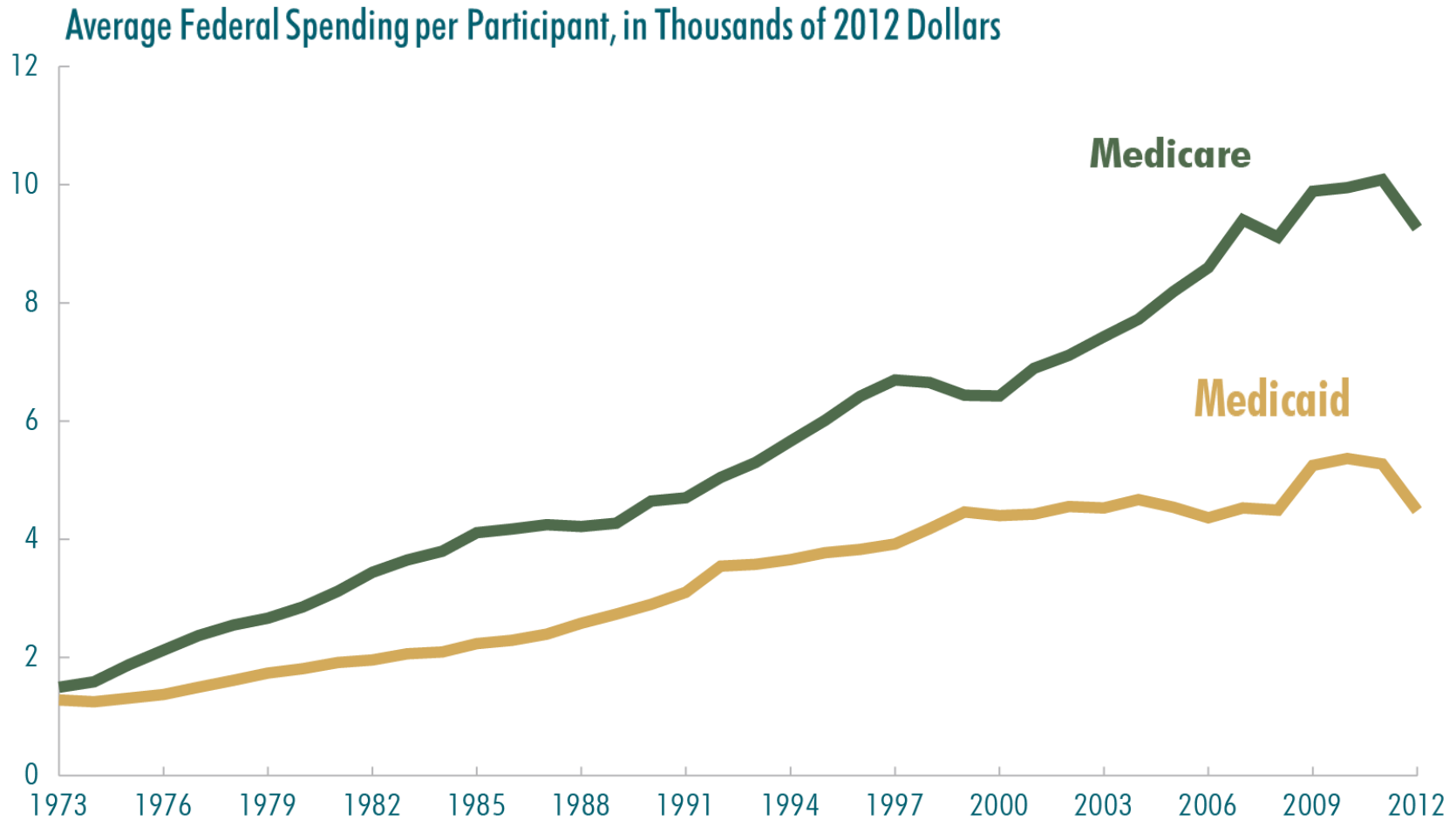
CBO's projections for 2024:



Federal spending in 2024 for the major health care programs will finance care for:



Health Care Costs per Person Have Risen Significantly, Even After Adjusting for Inflation



What Could Be Done About the Growth of Federal Health Care Spending?

CBO Analyzed a Wide Range of Possible Approaches in *Health-Related Options for Reducing the Deficit: 2014 to 2023*

Improve the health of the population

Reduce federal subsidies for health insurance

Pay Medicare providers in different ways

Make larger structural changes to federal health care programs

Undertake other possible reforms

Improving the Health of the Population Would Help People and Might (or Might Not) Help the Federal Budget

Possible federal policies include **taxes, subsidies, or other ways** to:

- Reduce smoking or obesity

- Increase screening for diseases

- Enhance compliance with regimens for chronic conditions

Presumed links between policy and the federal budget:

Change behavior → **Improve health** → **Reduce health care costs**

The federal budgetary effects depend on the combination of:

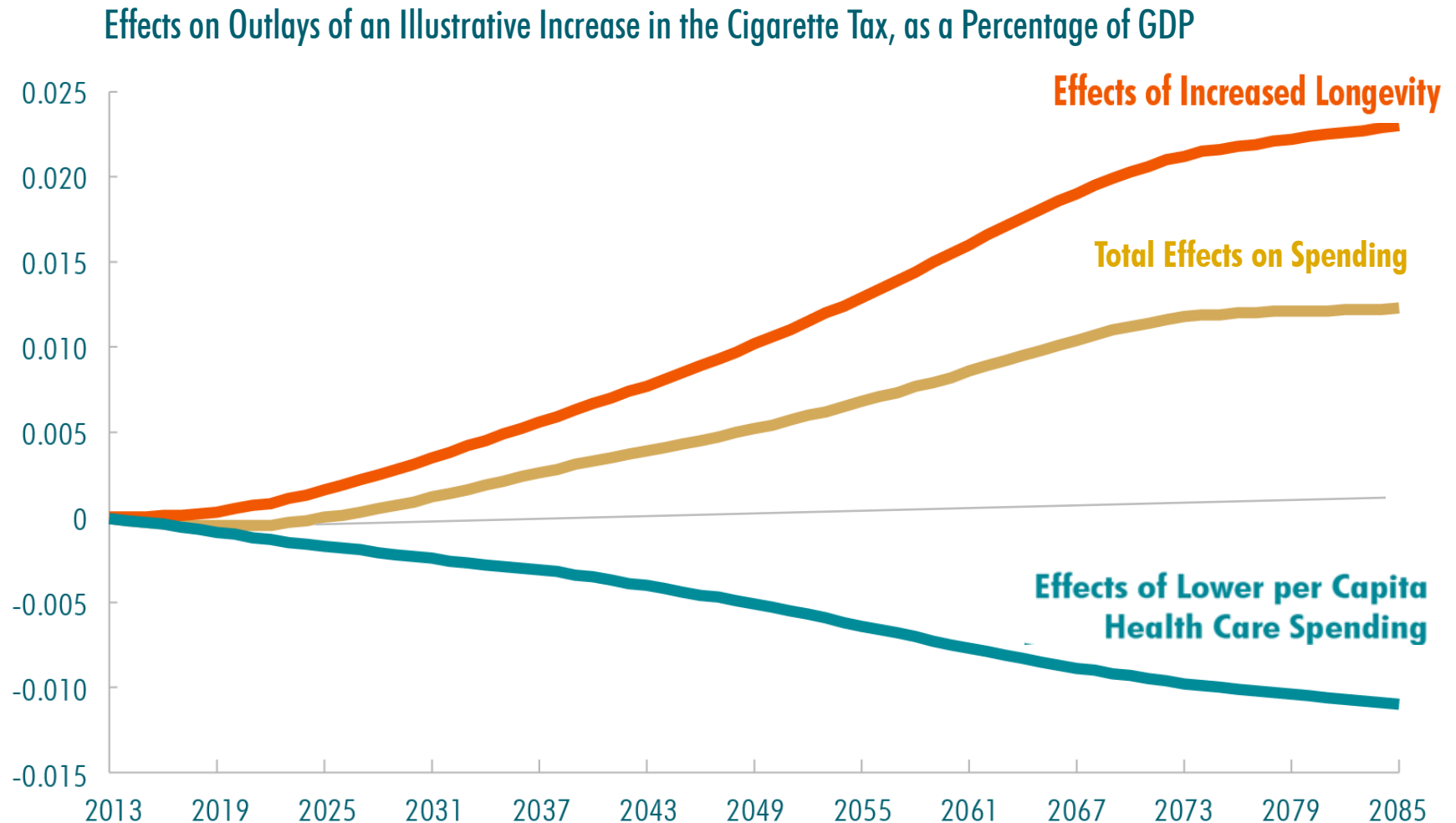
- Any reduction in annual health care costs per person

- Any increase in tax revenues from a larger or healthier workforce

- Any increase in costs for Social Security and health care benefits from people living longer

- Any budgetary cost or savings of the policy itself

For Example, an Increase in the Cigarette Tax Would Raise Federal Spending and Revenues



Reducing Federal Subsidies for Health Insurance Would Help the Budget But Would Make Affected People Bear Higher Costs

Possible federal policies include:

Repeal or narrow the expanded eligibility for subsidies under the ACA

Reduce the size of exchange subsidies under the ACA

Raise the eligibility age for Medicare

Increase premiums in Medicare

Increase cost sharing in Medicare

Reduce the tax subsidy for employment-based health insurance

For Example, Increased Cost Sharing in Medicare Would Help the Federal Budget and Reduce Total Health Care Spending But Impose More Burden on Beneficiaries

Medicare has separate deductibles for care from hospitals and doctors, and it has no catastrophic cap. In those ways, it is more complicated and provides less protection from financial risk than many private insurance plans. However, most Medicare enrollees have supplemental coverage (such as “medigap”) that reduces cost sharing.

The specifics of policy changes matter a lot: CBO analyzed options of this sort that would reduce deficits by between \$52 billion and \$114 billion over the next decade.

Paying Medicare Providers in Different Ways Might Help the Federal Budget But Would Have A Range of Effects on Providers and Beneficiaries

Possible federal policies include:

Shift physicians' payments away from the fee-for-service model

Bundle payments for related services

Federal savings would be achieved only if providers were paid less in total than under current law, either because they would be delivering fewer and less complex services or because they would be receiving less money per service.

For Example, Bundling Payments for Related Services in Medicare Might Help the Federal Budget and Enhance Care Coordination

Currently, most payments for health care in Medicare involve **separate payments for each service.**

Instead, **payments could be made for groups of related services.**

The specifics of policy changes matter a lot: CBO analyzed options of this sort that would reduce deficits by between \$17 billion and \$47 billion over the next decade.*

[*Sentence corrected on March 5, 2014]

Making Larger Structural Changes to Federal Health Care Programs Might Help the Budget But Would Have A Range of Effects on Providers and Beneficiaries

Possible federal policies include:

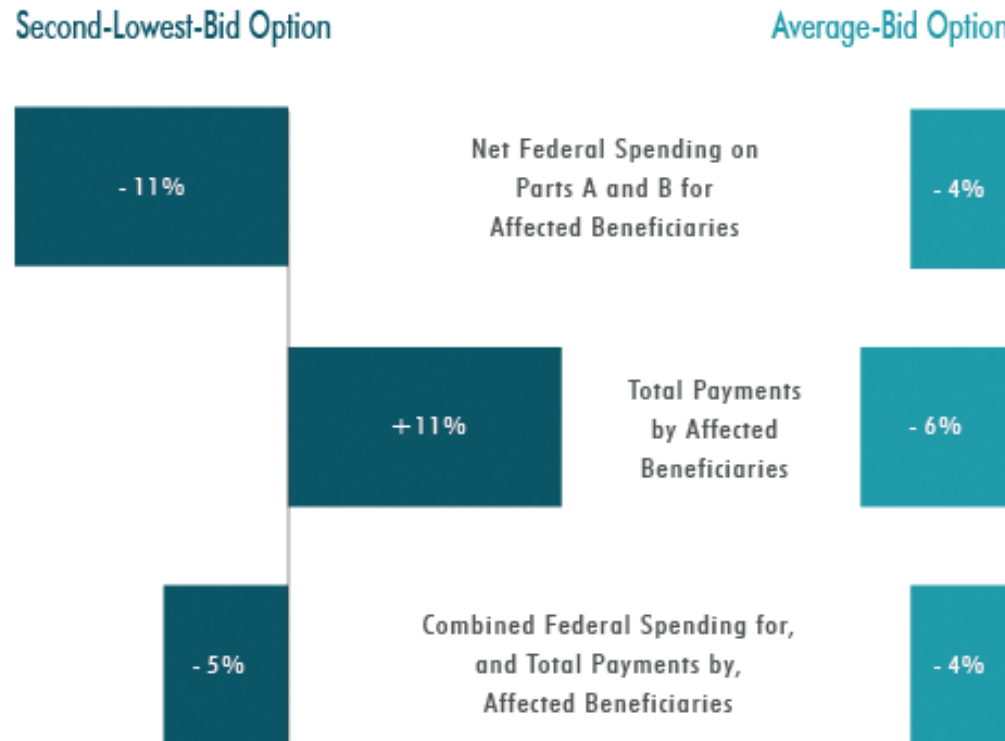
Adopt a premium support system for Medicare

Cap payments to states for Medicaid

Under either of those policies, numerous design choices would have very large effects on beneficiaries' costs, state governments' budgets, and the nature and magnitude of payments to providers.

For Example, a Premium Support System for Medicare Might Reduce Federal Spending and Might (or Might Not) Raise Costs for Beneficiaries

Effects of Options on Spending for Medicare Benefits



For Example, Capping Payments for Medicaid Might Reduce Federal Spending but Might Make States Bear Higher Costs and Might Reduce Care for Beneficiaries

Currently, federal Medicaid funding is provided on an **open-ended basis**, so increases in the number of enrollees or in costs per enrollee automatically generate larger payments to states.

If caps on payments were set low enough, **states would bear the burden** of higher costs by having to commit more of their own revenues, reduce services offered or eligibility, cut payment rates for providers, deliver services more efficiently, or some combination.

Conclusion

Federal lawmakers often strive for policies that both **reduce the growth of federal health care spending** and **improve the effectiveness of the national health care system**.

Designing federal policies to achieve those goals is challenging:

Most policies have **significant disadvantages as well as advantages**.

How health insurers, health care providers, and individuals would respond to most policies is uncertain.

Endnotes

Slide 2: “JCT” refers to the staff of the Joint Committee on Taxation.

Slide 6: For more information on the estimates for 2014, see *The Budget and Economic Outlook: 2014 to 2024* (February 2014), www.cbo.gov/publication/45010. For more information on the projections for 2038, see *The 2013 Long-Term Budget Outlook* (September 2013), www.cbo.gov/publication/44521; values for 2038 are from CBO’s latest extended baseline, which is based on CBO’s May 2013 10-year budget projections. Major health care programs consist of Medicare, Medicaid, the Children’s Health Insurance Program, and subsidies offered through health insurance exchanges and related spending; Medicare spending is net of offsetting receipts.

Slide 7: For more information, see *The Budget and Economic Outlook: 2014 to 2024* (February 2014), www.cbo.gov/publication/45010. CHIP refers to the Children’s Health Insurance Program.

Slide 8: For more information, see *The Budget and Economic Outlook: 2014 to 2024* (February 2014), www.cbo.gov/publication/45010. CHIP refers to the Children’s Health Insurance Program.

Slide 9: For more information, see *The 2013 Long-Term Budget Outlook* (September 2013), www.cbo.gov/publication/44521. Rising costs of health care per person are measured based on so-called “excess cost growth,” which is the amount by which health care costs per beneficiary (adjusted for changes in the age profile of beneficiaries over time) outpace the maximum sustainable output of the economy per person.

Slide 10: For more information, see *The 2013 Long-Term Budget Outlook* (September 2013), www.cbo.gov/publication/44521.

Slide 11: For more information, see *The Budget and Economic Outlook: 2014 to 2024* (February 2014), www.cbo.gov/publication/45010.

Slide 12: Projections prepared by CBO and the staff of the Joint Committee on Taxation.

Slide 13: Medicare spending is net of offsetting receipts.

Slides 15 through 24: For more information, see *Health-Related Options for Reducing the Deficit: 2014 to 2023* (December 2013), www.cbo.gov/publication/44906.

Slide 17: For more information, *Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget* (June 2012), www.cbo.gov/publication/43319.

Slides 22 and 23: For more information, see *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), www.cbo.gov/publication/44581.